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Agency of Human Services

Request for Proposals or Bids

By the Agency of Human Services
For
Psychiatric Acute Care Services To Replace Vermont State Hospital

Issue Date: June 29, 2009

Request for
Proposals or Bids
Psychiatric Acute Care Services
To Replace Vermont State Hospital

We, Vermonters, hold a broad common vision regarding mental health care: we expect services to be of high quality and to be provided in a holistic, comprehensive continuum of care, where consumers are treated at all times with dignity and respect, where individual rights are protected, where public resources are allocated efficiently and produce the best positive outcomes, and where direct services overseen and provided by the Agency of Human Services and its community partners are person- and family-centered and driven, are accessible, and are culturally competent. We also share the understanding that all interventions must reflect the most integrated and least restrictive alternatives necessary.

PURPOSE

The Vermont Agency of Human Services, Department of Mental Health Futures Project, seeks formal bids or conceptual proposals for the provision of acute psychiatric inpatient services to replace the Vermont State Hospital (VSH).

In 2004, the Legislature and the administration set in motion a strategic planning process to create a comprehensive plan for the delivery of services currently provided by VSH within the context of long-range planning for a comprehensive continuum of mental health care.

In February 2005, the Department of Mental Health and the Secretary of the Agency of Human Services provided the legislature with an initial plan to replace Vermont State Hospital.

The plan proposed new investments in the essential community capacities, and reconfiguring the existing 54-bed inpatient capacity at the Vermont State Hospital into a new system of inpatient, rehabilitation, and residential services for adults. This approach is consistent with Vermont's long history of establishing strong community support systems to reduce reliance on institutional care. The fundamental goal is to support Vermonters with mental illness in the least restrictive and most integrated settings that promote recovery.

Historically the Vermont State Hospital has provided acute psychiatric inpatient services and longer term rehabilitation services in a secure setting for individuals in the care and custody of the Commissioner of Mental Health. The Futures Plan replaces the longer term rehabilitation roles provided by VSH with the development of new residential programs; specifically Second Spring (14 beds), Meadowview (6 beds in development) and the Secure Residential Recovery Program (15-beds, proposed).

The Department of Mental Health is issuing this request for bids or conceptual proposals to provide the opportunity for every hospital in Vermont, and any other interested parties, to propose replacing the acute psychiatric inpatient functions currently provided at Vermont State Hospital. The responses to this offer will inform the development of the legislatively required "master plan to replace the functions now provided in Vermont State Hospital".

Specifically, the 2010 Capital Bill enacted into law requires the following.

Sec. 30. VERMONT STATE HOSPITAL; REPLACEMENT

(a) It is the intent of the general assembly that expenditures for planning for replacement of the functions of the Vermont state hospital shall be directed toward meeting the conditions and requirements of the conceptual certificate of need issued by the department of banking, insurance, securities, and health care administration on April 12, 2007, and extended for 12 months, to expire on April 12, 2010.

(b) Prior to the submission of an application for a phase II certificate of need for construction of a facility to house a secure residential recovery program provided for in Sec. 31 of this act, ***the department of mental health shall develop a master plan to replace the functions now provided in the Vermont state hospital and to close the Vermont state hospital.*** *The master plan shall include an adequate long-range perspective of the funding needs and sources such that the phase II review process for a secure residential recovery program will be able to:*
(1) consider whether there will be an appropriate balance between the fiscal and other needs of current and future inpatient facilities and the fiscal and other needs of the community mental health system; and

(2) consider the state's financial ability to complete the master plan.

(c) While pursuing the secure residential facility as described in Sec. 31 of this act and ***the planning for acute mental health care in several hospitals geographically distributed throughout the state as provided for in Sec. 32 of this act, the department of mental health shall enter into discussions with general and specialty hospitals to explore options for hospital-level care for the remaining placements needed to close the Vermont state hospital.***

TWO LEVELS OF RESPONSE

This request for bid or conceptual proposal request is designed to facilitate two levels of response. First is to solicit actionable bids that reflect significant planning work accomplished to date and for which Certificate of Need application would be filed within one year. The structure for bids follows closely to the Vermont Certificate of Need Requirements to facilitate public review and efficient preparation of a CON application. Responsive bids would include detailed approach to licensing, facilities plans, and services costs, programming description, anticipated revenues and payer mix.

The second type of response is for a conceptual proposal committing the responding organization to planning for a potential future bid and CON application. Such proposals would reflect a stage of planning that is not sufficiently developed to make a bid. This may include outstanding licensing issues, governance and ownership questions, facility

and staffing design in early development, or generally a stage in which the exploration of different options needs to proceed in order to develop a specific project plan.

BACKGROUND INFORMATION

The following section outlines the planning and policy development history for the Vermont State Hospital (VSH) Futures project and provides a description of the patient population served at the current. Responsive bids or conceptual proposals should reflect this policy background and be designed to meet the needs of the patient population described.

Planning History to Date

Planning 2004 - 2005

In 2004, the Legislature and the Douglas administration set in motion a strategic planning process to create a comprehensive plan for the delivery of services currently provided by VSH within the context of long-range planning for a comprehensive continuum of mental health care.

On December 16, 2004 the Division of Mental Health issued an RFI to solicit partners to develop the emerging concepts for inpatient and community capacities to replace VSH. The RFI was sent to fourteen Vermont Hospitals and ten Designated Agencies. Four hospitals responded to the RFI: Springfield Hospital, Fletcher Allen Health Care, Rutland Regional Medical Center, and Brattleboro Retreat.

The work of the Futures Advisory Committee and the responses to this RFI formed the basis of the February 2005 *Comprehensive Plan to Replace Vermont State Hospital* that the Department of Health (Division of Mental Health) and the Secretary of the Agency of Human Services submitted to the legislature.

The plan proposed new investments in the essential community capacities, and reconfiguring the existing 54-bed inpatient capacity at the Vermont State Hospital into a new system of inpatient, rehabilitation, and residential services for adults. This approach plan is consistent with Vermont's long history of establishing strong community support systems to reduce reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illness in the least restrictive and most integrated settings that promote recovery.

In May 2005 as part of the FY 06 Appropriation Bill (Sec. 113e) the Legislature began appropriations for new community services to replace Vermont State Hospital. The language reflects general policy consistent with planning to date:

"(a) The General Assembly adopts the principles in the May 31, 2005 draft report from the Department of Health for restructuring the delivery of mental health services currently received in the Vermont State Hospital, including the following:

(1) The current state hospital facility should be replaced with a facility or facilities with fewer than 54 beds and with meaningful programmatic integration of medical and community mental health services.

(2) As the replacement occurs, the operations and human resources in the state hospital should be supported and enhanced to ensure safety and the clinical programming should effectively support recovery.

(3) The capacity and network of community services should be expanded to meet patient needs in a clinically appropriate manner consistent with system values".

Policy Context
Planning for the future of the mental health care system is based on nine considerations outlined by the Legislature, which reflect the commonly held values of the agency and the mental health provider and stakeholder communities:

(1) an understanding of the role of active treatment in the goal of recovery;
(2) an understanding of the role of trauma in the lives of individuals;
(3) accessible general medical care;
(4) minimal use of involuntary interventions such as seclusion, restraint, and involuntary medication;
(5) staff training in the use of safe and appropriate alternatives to involuntary interventions;
(6) consumers' participation in the development and implementation of their treatment plans;
(7) consumers' right to privacy and the right to have information regarding their care remain confidential, unless disclosure is authorized by the consumer or required under the law;
(8) ongoing consumer and community input with regard to program oversight and development; and
(9) accountability for all components of the mental health care system.

Throughout calendar year 2005 the VSH Futures Advisory Committee continued work to identify criteria for the selection of inpatient services sites and partners. On November 16, 2005 the committee formally endorsed the following recommendation to AHS Secretary Mike Smith about the sustainability of the MH Services System, the selection criteria for the inpatient service sites and partners, and the scope of the needed services infrastructure to successfully implement the Futures Plan.

"Planning for the Futures project, for both inpatient and community services needs to occur in the context of considering the overall financial health of the Designated Hospital and Agency service providers."

"The VSH Futures Advisory Committee notes that its "support in concept" for the overall Futures plan, and its formal votes regarding advancing specific components, all

remain contingent upon the scope of the plan as presented to the legislature last February. We do not believe that, in significant part based on prior direct experience, a replacement inpatient unit alone with or without the addition of sub acute beds can succeed in meeting the needs of the population that VSH serves. These components include the addition of emergency observation, diversion and step-down beds, additional housing, additional community services, additional peer support services, and non-traditional alternatives. It also assumes continuation of adequate resources to sustain all existing community services, including designated inpatient programs, and caseload growth. The Committee notes that the expectation is that it will see appropriate activities and funding for these components in the FY 07 budget in accordance, at a minimum, with the programs identified as and budgeted as coming on line in FY 07 in the time line that targets a new inpatient facility opening in June, 2010; and that any expedited time line would also expedite the associated program components in the budget."

Primary Site & Partner Selection Criteria

1. *The primary VSH replacement service should not be an IMD*
2. *It should be attached to or near (in sight of) a tertiary / teaching hospital*
3. *Only designated hospital inpatient providers shall be considered for the primary VSH-replacement program until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.*
4. *There must be adequate space to develop or renovate a facility that will accommodate census needs.*
5. *The partner must agree to participate in the care management system. This assures a single standard of care, common clinical protocols, zero reject of eligible admissions etc.*
6. *Costs - both ongoing operations and capital construction - should be considered.*
7. *Outdoor activity space should be readily accessible to the units.*
8. *The ability to attract and retain sufficient specialty staff experienced in psychiatric care should be demonstrated.*
9. *The proposed partner's motivation, track record, and experience in partnering with the state and system of care should be considered.*
10. *Openness and past experience in including consumers/stakeholders in program design and quality monitoring should be demonstrated.*
11. *Willingness to participate in a public reporting of common quality standards is required.*
12. *Ability to deal with expedited planning time frame for full implementation to out-pace five year timeline.*
13. *Ability to collaborate with neighbors.*
14. *Ability to work closely with state and designated agency partners*
15. *The partner must be prepared to commit to support of the state public policy goal to work towards a system that does not require coercion or the use of involuntary medication.*

Smaller Inpatient Capacity(s)
Site and Partner Selection Criteria

1. *Preference should be given to Designated Hospital inpatient providers until such time as it is demonstrated that an agreement cannot be negotiated with one of these partners.*
2. *A location consideration is to assure adequate distribution of services throughout the state.*
3. *Ability to provide adequate on-site medical care and demonstrated access to hospital medical services.*

The rest of the criteria are the same as for the primary site

Planning 2006 - 2007
In March and April 2006, the Mental Health Oversight Committee and the Joint Fiscal Oversight Committee voted to approve, the Futures Strategic Implementation Plan as required by statute. This vote approved developing:

- **32 new inpatient beds** at two new levels of inpatient care, "intensive care" and "specialized care", in three locations: Fletcher Allen Health Care, Rutland Regional Medical Center and Brattleboro Retreat.

- **18 residential recovery beds** designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care.

- **6 secure residential recovery beds** designed to meet the needs of a longer-term care population currently served at VSH who require a secure, non-hospital environment.

- **10 crisis beds** designed to stabilize an individual's psychiatric crisis within a community setting and to divert admissions to hospitals.

In addition, the plan authorized development of a ***Care Management Program*** to ensure that the system can manage and coordinate access to high-intensity services; new ***Peer Programming*** to offer effective, recovery-oriented supports; resources to create secure, alternative ***Transportation*** options to the current system of using sheriffs and new ***Supportive Housing*** resources.

Regulatory Review
In August of 2006, the Division of Mental Health applied for a Conceptual Certificate of Need (CCON) for Planning from the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) to replace the inpatient functions of Vermont State Hospital. The CCON application proposed to create a primary inpatient program with Fletcher Allen Health Care and to expand the capacities at Rutland Regional Medical Center and the Brattleboro Retreat. The theoretical capital costs to develop a 40-

bed program with FAHC were $43 - $60 million depending on the degree of physical integration with the existing inpatient core on the Burlington campus. An option to create a 68-bed integrated facility (combining the VSH replacement program with the existing 28-bed FAHC inpatient psychiatric program) was estimated to cost $69 - $86 million. Proposed renovation and expansion of the existing unit at Rutland Regional Medical Center was estimated to cost between $7 – 13.4 million. Capital cost estimates to develop the proposed VSH replacement beds at Retreat Healthcare were not developed for the CCON application.

BISHCA granted a two-year CCON for planning to replace VSH on April 12, 2007. The Certificate endorsed the need to replace the antiquated facility in Waterbury and directed the Division of Mental Health to assess the feasibility of creating a new 50-bed hospital in addition to exploring any other viable option. BISHCA granted a one year extension of the CCON in early April, 2009.

Legislative Independent Study & Option Analysis

There was little legislative support for the proposed construction of a primary inpatient program with Fletcher Allen Health Care. The Legislature commissioned an independent study to review the planning to date and options for future development. The independent study provided its recommendations in November 2007 to the General Assembly. These included developing a state-run secure residential program, revising the process or statutory framework for non-emergency involuntary medication, developing inpatient care with general hospitals, and taking an incremental approach to the capital development of the project.

In the spring and summer of 2007 Commissioner Hartman and Deputy Tanzman met personally with each of Vermont's fourteen hospitals to solicit interest in partnering to develop new inpatient programs to replace Vermont State Hospital. At that time the Brattleboro Retreat, FAHC, and RRMC expressed direct interest in planning to develop new inpatient capacities to replace VSH. Springfield Hospital expressed interest - however, it did not seem possible at that time to overcome the limit of ten (10) beds for a psychiatric program within a hospital designated as a "Critical Access Hospital".

Throughout the summer and fall of 2007, the Department of Mental Health (DMH) assessed the feasibility of 21 different options including a 50-bed hospital, three 16-bed hospitals, and configurations of 32, 12 and 4 beds. These options were developed in collaboration with FAHC, Retreat Health Care, and Rutland Regional Medical Center. The analysis included operating costs, architectural feasibility, construction costs and policy considerations. The results were reported to the Legislative Mental Health Oversight Committee in November 2007.

Based on this analysis, DMH focused on developing a secure residential recovery program, an expansion of the inpatient capacity at Rutland Regional Medical Center, and longer range planning for the remaining inpatient beds.

Summary and Current Status

In consideration of the proposed planning to replace VSH, policy makers and stakeholders expressed concerns about the advisability of moving forward incrementally to replace parts of VSH without having an overall framework for how the Vermont State Hospital would ultimately be closed and the replacement services funded. In addition, the legislature heard testimony from the Brattleboro Retreat, Springfield Hospital, and Northeastern Vermont Regional Hospital indicating interest and capability to provide new or expanded psychiatric inpatient services. Consequently, it is entirely fitting to again formally solicit the interest of any potential organization to provide acute psychiatric inpatient care to replace Vermont State Hospital.

The Patient Population and Program Requirements

Psychiatric Inpatient System of Care

There are seven licensed psychiatric inpatient programs for adults in Vermont as follows:

Table 1
Vermont Adult Inpatient Psychiatric Programs and Designation

Hospital	Licensed Capacity	Designated for Involuntary Care	Designated for Forensic Evaluation
Vermont State Hospital	54	Yes	Yes
Brattleboro Retreat	46	Yes	Yes*
Central Vermont Hospital	14	Yes	No
Fletcher Allen Health Care	28	Yes	Yes*
Rutland Regional Medical Ctr.	19	Yes	Yes*
Springfield "Windham Ctr."	10	Yes	No
Veteran's Administration	10	No	No

*Rarely provide psychiatric inpatient services to individuals undergoing a forensic exam to determine competency and sanity

Daily census reports to the Vermont Department of Mental Health from January 1, 2009 through May 30th 2009 indicate the following occupancy rates for these hospitals. Note, the Veteran's administration does not report occupancy to DMH.

Table 2
January – May 2009 Average Occupancy Rates

Hospital	Average Occupancy Rate 1-5/31/2009
Vermont State Hospital	89%
Brattleboro Retreat	84%
Central Vermont Hospital	75%
Fletcher Allen Health Care	81%
Rutland Regional Medical Ctr.	80%
Springfield "Windham Ctr."	87%

In information derived from the most recently available Vermont Uniform Hospital Discharge Data Set maintained by the Vermont Department of Health, in calendar year 2007 there were **2,338** episodes (admissions) of inpatient behavioral (mental health and substance abuse treatment) health care treatment for adult Vermonters. Of these, there were **243** admissions to Vermont State Hospital.

VSH Role and Population Served

Vermont State Hospital plays a unique role in Vermont's overall system of care; it provides care to individuals with higher acuity, greater risk for dangerous behavior, longer term stays and/or who require involuntary medications under ACT 114.(a) The patients admitted to Vermont State Hospital are almost exclusively involuntary. It also has been the primary, if not the only location for inpatient competency and sanity evaluations for individuals charged with a crime.

VSH currently is the only hospital in the system that admits any patient who meets admission criteria. The DMH and the DHs have specifically agreed that, in the current system, DHs have the option to decline an admission they assess as too acute to treat safely in their facility.

Table 3 shows a 14-year history of the admissions to VSH and their legal status.

Table 3: Vermont State Hospital Admissions Legal Status
Fiscal Years 1995 – 2004

Fiscal Year	Total Admissions	Voluntary Admissions		Emergency Admissions		Forensic Admissions		Other Admissions(b)	
2008	278	16	6%	162	58%	93	33%	6	2%
2007	243	35	14%	128	53%	75	31%	5	2%
2006	215	23	11%	106	49%	75	35%	11	5%
2005	200	9	4%	76	39%	99	49%	16	8%
2004	219	13	6%	95	43%	103	47%	8	4%
2003	216	16	7%	84	39%	104	48%	12	6%
2002	240	14	6%	115	48%	97	40%	14	6%
2001	221	8	4%	100	45%	106	48%	7	3%
2000	224	10	4%	114	51%	84	38%	16	7%
1999	224	5	2%	90	40%	115	51%	15	7%
1998	304	6	2%	161	53%	122	40%	15	5%
1997	302	11	4%	152	50%	115	38%	24	8%
1996	289	3	1%	178	62%	86	30%	22	7%
1995	313	9	3%	189	60%	95	30%	20	7%

(a) Act 114 sets out the legal process and implementation procedures for the provision of non-emergency involuntary psychiatric medications.
(b) "Other" admissions are all involuntary and refer to revocation of conditional release, revocation of orders of non-hospitalization and inter-state transfers.

Emergency Exams and Forensic Evaluations

There are two primary admission routes to Vermont State Hospital – Emergency Exams (EEs) and Forensic Exams (Observation).

Currently, all emergency examinations (EEs)(c) are first proposed for admission to Designated Hospitals. Designated Hospitals now serve twice as many emergency exams as does the Vermont State Hospital. In *calendar* year 2008 there were **367** emergency exam (EEs) admissions to Designated Hospitals and there were **139** EEs to VSH. In addition, the designated hospitals transferred **34** EE admissions to Vermont State Hospital.

Characteristics of Patients Served at VSH

Understanding the treatment needs of patients who are not currently able to be served at the existing Designated Hospital programs is critical to developing inpatient capacity that can replace Vermont State Hospital. Table 4 shows the reasons provided by Designated Hospitals for referring emergency exam admissions to VSH in calendar year 2008.

Table 4: 2008 EE Admissions to VSH
Referred from Designated Hospitals

	No Bed	Patient Acuity[1]	Unit Acuity[2]	Lack of Insurance[3]	Out of County Referral	Patient Refuses Treatment[4]	Do Not Admit List	Medical Issues	Not Reported	Other
FAHC	38	52	8	0	0	4	0	0	5	1
CVMC	19	71	3	0	0	5	2	0	7	1
RRMC	58	33	5	0	1	2	0	0	7	2
WC	48	45	2	1	0	4	1	1	6	0
BR	32	45	7	10	0	3	0	2	6	3

FAHC = Fletcher Allen Health Care RRMC = Rutland Regional Medical Center
CVMC = Central Vermont Medical Center WC = Windham Center BR = Brattleboro Retreat

(c) Admissions for Emergency Examinations (EE) occur upon written application by an interested party (usually the DA screener), accompanied by a certificate signed by a physician who is not the applicant. The application sets forth facts and circumstances that indicate the need for an emergency examination according to the following standards: the person must have mental illness, be in need of treatment, and be dangerous to self or others, and it must be the case that no less-restrictive alternative is sufficient.

It is difficult to compress the heterogeneity of the VSH acute patient population into meaningful categories: schizophrenia and other psychotic disorders are the most frequent diagnoses; most people admitted are between the ages of 20-49, slightly more than half of admissions are male, and in FY 2007 approximately 31% of the admissions were for forensic evaluation. For additional demographic characteristics please refer to the Annual Statistical Reports published by the Department of Mental Health.

Forensic Evaluation: Provision of inpatient evaluation and treatment for individuals charged with a crime.

Forensic admissions to VSH refer to court-ordered observation evaluations that are performed in an inpatient setting. An independent forensic psychiatrist sees the defendant to determine if he or she was insane at the time of the alleged offense, and/or is competent to stand trial for the alleged offense. Admissions for observation occur when a district court sends a criminal defendant to VSH for a psychiatric evaluation. The courts are required to consult with a qualified mental health professional who, in turn, makes the recommendation for the most appropriate site for the forensic evaluation to occur – inpatient or outpatient. (d) In SFY 08, the courts commissioned 291 observation evaluations, of which 35% percent were completed at VSH, 65% percent in the community. Qualified mental health professionals are expected to recommend inpatient evaluations only if the individual's mental health treatment needs meet criteria for inpatient treatment.

As Table 3 shows, over the past 10 years, forensic admissions account for between 30 and 50 percent of all admissions to VSH. For those evaluations that occur at VSH, if the evaluator finds that the defendant is competent, a hearing can be held within 48 hours, and the defendant is returned to DOC oversight. If the finding is that the defendant is incompetent to stand trial, the state usually will seek an order for continued treatment to restore competency. This treatment can occur on an inpatient or outpatient basis depending on the treatment needs of the individual. The number of Forensic admissions annually to VSH (See Table 1), has historically been fairly consistent.

In addition to VSH, three other hospitals are designated to provide in patient treatment services for individuals remanded by the court for a forensic evaluation (FAHC, RRMC, and Retreat HealthCare). At this time virtually all referrals come to VSH and occasionally Retreat Healthcare will admit a forensic evaluation.

(d) An analysis conducted in 2009 revealed that judges and screeners disagreed about 14% of the time.

Additional Considerations

Psychiatric Inpatient Services for Incarcerated Individuals
DOC has a small population, variously estimated (e) from two - four persons at any given need of hospitalization. They cannot be appropriately placed because current inpatient sites lack sufficient security to protect care givers, other patients, and the therapeutic environment.

Provision of non-emergency involuntary psychiatric medication under Act 114.(f)
VSH is the currently the only program in which non-emergency involuntary medication under the terms of Act 114 is provided. Any successor program to VSH will need to provide for this consistent with Vermont Statutes. Table 5 shows the number of petitions for non-emergency involuntary medication filed since Act 114 has been implemented. Generally, petitions for non-emergency involuntary medications are granted.

Table 5: Petitions for Non-emergency Involuntary Medication
State Fiscal Years 2002 - 2009

State Fiscal Year	# Petitions Filed
2002	27
2003	21
2004	27
2005	24
2006	16
2007	39
2008	25
2009	24

Summary
Broadly speaking, the acute care population at Vermont State Hospital can be described in the following two clusters – both of which differentiate VSH patients from those served at Designated Hospital programs.

Individuals requiring more than 30 days of intensive inpatient care. The average length of stay at DH psychiatric programs over the past 10 years has been between seven and nine days. During the same time period, the average length of stay at VSH has ranged from 63 to 76 days. Individuals staying longer than one month account for 60 percent of

(e) DOC independently made this assessment and later a Futures working group in collaboration with the DOC medical director developed an alternative methodology to estimate acute inpatient bed needs. This estimate continues to be controversial in part because of the belief shared by many stakeholders that there is a much larger DOC population that is underserved and would benefit from more intensive and comprehensive mental health services
(f) Act 114 sets out the legal process and implementation procedures for non-emergency, involuntary psychiatric medications

the VSH bed days. The wide variance in length of stay between VSH and the other Vermont inpatient programs points to different care practices and also to different clinical needs of the populations served. These individuals require intensive, multi-disciplinary treatment in a secure inpatient setting.(g) They are at high risk for dangerous behavior such as suicide and assault, may need intensive medical care, and may require non-emergency, involuntary medication to ameliorate symptoms and restore capacity.(h) Individuals with psychiatric disabilities who are currently incarcerated and in need of inpatient care could be among those who meet this description.

Individuals requiring brief, intensive inpatient care. These individuals also require intensive, multi-disciplinary treatment in a secure inpatient setting. The clinical emphasis is on assessment and the development of a treatment plan to stabilize symptoms and to move the patient to an appropriate, less restrictive and more integrated level of inpatient, rehabilitation, or community care.

SCHEDULE FOR ISSUING RFP AND CONDUCTING REVIEW

June 29, 2009	Issue RFP
July 20, 2009	Deadline for receipt of letter of intent to bid
August 28, 2009	Deadline for bids and conceptual proposals
September 11, 2009	DMH issues questions to submitting organizations
September 18, 2009	Responses to questions due
September 30, 2009	Review Committee recommendations to Commissioner
October 19, 2009	Commissioner develops draft "Master Plan to replace the functions now provided at VSH"
Oct 20 – Nov 30, 2009	Legislative review / consultation
December 15, 2009	Legislative Approval of Master Plan

(g) "Intensive, multi-disciplinary treatment in a secure inpatient setting" consists of state-of-the-art diagnostic, behavioral, motivational engagement, and medical services, all provided in a continuous and ongoing manner

(h) Having this capacity is not the same as accepting medication. Having capacity means having the ability to make an informed choice about accepting or rejecting the treatment proposed. Involuntary treatment is strongly opposed by some advisory group members and its avoidance is articulated in law as a state policy

INSTRUCTIONS TO BIDDERS

Proposal/Bid Format
Use standard 8.5" X 11" white paper. Documents must be single-spaced and use not less than a twelve-point font. Pages must be numbered. The proposal should be comprehensive, yet concise. The proposal must follow the sequence of information requested in the "Bid Requirements" section below. State your organization's name on each page of your program proposal/bid and on any other information you are submitting.

Letter of Intent
In order to ensure all necessary communications with the appropriate bidders and to prepare for the review of proposals, one letter of intent to bid must be submitted per bidding agency.

Letters of Intent must be submitted by July 20, 2009 by 4:00 pm EST to:

Beth Tanzman
Deputy Commissioner
Vermont Department of Mental Health
108 Cherry Street, P.O. Box 70
Burlington, VT 05402
RE: Psychiatric Acute Care Services to Replace Vermont State Hospital

An electronic copy of the Letter of Intent should also be submitted to:
beth.tanzman@ahs.state.vt.us

Delivery of Proposals
Proposals must be received no later than at 4:00 pm EST on August 28, 2009 at the following address:

Beth Tanzman
Deputy Commissioner
Vermont Department of Mental Health
108 Cherry Street, P.O. Box 70
Burlington, VT 05402
RE: Psychiatric Acute Care Services to Replace Vermont State Hospital

An electronic copy of the Application should also be submitted to:
beth.tanzman@ahs.state.vt.us

Public Disclosure
All proposals shall become the property of DMH. All proposals will be posted on the DMH website.

All public records of DMH are available for disclosure. The proposals sought by the RFP will be reviewed by DMH staff as well as a review panel composed of stakeholders such

as DA staff, consumers and advocates. Applicants should be aware that information submitted will be shared with the review panel, so propriety information should not be included in the proposal.

Costs of Proposal Preparation
DMH will not pay any bidder costs associated with preparing or presenting any proposal in response to this RFP.

Receipt of Insufficient Competitive Proposals/Bids
If DMH receives one or fewer responsive proposals/conceptual bids as a result of this RFP, DMH reserves the right to select a Contractor, which best meets DMH's needs. The Contractor selected need not be the sole bidder but will be required to document their ability to meet the requirements identified in this RFP.

Non-Responsive Proposals/Waiver of Minor Irregularities
Read all instructions carefully. If you do not comply with any part of this RFP, DMH may, at its sole option, reject your proposal as non-responsive.

DMH reserves the right to waive minor irregularities contained in any proposal or to seek clarification from the bidding agency.

RFP Amendments
DMH reserves the right to amend this RFP. DMH will mail any RFP amendments to all bidders who sent a Letter of Intent.

Right to Reject All Proposals
DMH may, at any time and at its sole discretion and without penalty, reject any and all proposals and issue no contract as a result of this RFP.

Authority to Bind DMH
The Commissioner is the only person who may legally commit the Department of Mental Health to personal services, client service, and information service contracts. The Contractor shall not incur, and DMH shall not pay, any costs incurred before a contract is fully executed.

The Department of Mental Health reserves the right to accept or reject any or all bids. The proposals will be evaluated by the staff of DMH, legislators and other mental health stakeholders. Bids or conceptual proposals selected will become part of the "Master Plan" as required by the 2010 Capital Bill enacted into law by the General Assembly. Additional planning, including CON application(s) and review will be required to implement the Plan.

Information about the Futures Project and the Department of Mental Health Activities

Prospective applicants are referred to the Department's web site for information about the Futures Project, its work to date and all related reports from Department staff and consults. The Futures Project web site address is:
http://healthvermont.gov/mh/futures/futureshome.aspx

BID REQUIREMENTS

Statement of Need

The Vermont Department of Mental Health (DMH) requests bids or proposals to replace the acute inpatient psychiatric care currently provided at Vermont State Hospital in Waterbury Vermont. The projected planning need is for 30 – 35 inpatient beds to support approximately 275 admissions annually.

DMH will accept bids for any number or combinations of beds up to thirty-five.

Bids or proposals should reflect the planning and project principles outlined in the background and introduction of this document or offer a counter argument for exceptions.

Selected Bids or Conceptual Proposals will be included in the "Master Plan to replace the functions now provided in the Vermont state hospital and to close the Vermont state hospital".

Indicate whether this is a bid or a conceptual proposal.

I. Conceptual Proposal

If this is a conceptual proposal please describe the options under consideration, timeframe for resolution, and any requirements needed (such as a waiver of an existing licensing rule or change in statute). Describe, in detail the approach, timeframe and expected milestones to secure any waivers required for Medicare of Medicaid participation. Describe, in detail, the approach, timeframe and expected milestones for any proposed licensing arrangement.

Please address as many of the bid requirements as possible at this time. Please specifically note if your concept proposal anticipates not being able to address or fulfill any of the requirements.

II. Bid Requirements

Please describe the project approach to the following requirements.

1. Program Description

Provide a summary description of the organization making the bid or conceptual proposal. Describe what is being proposed in terms of the number of beds, physical location of these beds, relationship of the expansion program to the existing program (if relevant), and proposed plan for licensure and governance. Also describe the clinical, medical, and psycho-social programming proposed. The program of space should reflect the full range of clinical, administrative, operational and adjunctive therapies support available at a typical modern free-standing state hospital.

In addition, please provide a detailed timeline for commencement of the program that includes dates for all key implementation tasks. If your proposal is to continue or expand an existing program, the implementation plan should include a timeline for admission of remaining patients to the program and program components not yet operational.

Please include any other information that will assist policy makers to evaluate and understand your proposal.

2. Program of Space

The Vermont State Hospital Futures Project staff, in collaboration with stakeholders and the Vermont Department of Buildings and General Services developed a basic program of space for any VSH successor inpatient program. This program of space reflects current inpatient architectural standards and optimal treatment facility. The hallmarks are single room, single bathroom; residential sub-clusters that provide treatment and living space; shared common areas; and access to the outdoors. The approach uses the concept of "neighborhood" for shared and more public spaces with 'residential cluster" for private patient areas. Appendix 1 provides two documents describing the basic program of space standards developed by the mental health stakeholder community as part of the Futures Project. The first is a set of concepts to inform the architectural design of the proposed project. The second document is a sample summary program of space for a 16-20 bed facility. Prospective bidders are asked to use this as a template in developing their response.

Responsive bids / proposals will:

A: Specify whether their proposal reflects (a) a stand-alone independent program; or (b) a program integrated into a larger inpatient facility. Indicate the total number of VSH replacement beds as well as the total number of facility psychiatric beds. Also please state whether the proposed unit(s) will be divided into sub-clusters, and, if divided, specify the number of beds per cluster.

B: Define the assumptions made with respect to the facility Concept of Operations as this affects the degree of architectural integration that may occur with an existing hospital, and impacts architectural design and construction cost.

C: Provide the rationale for deviations from the template summary program of space. Especially, indicate whether the bid or proposal deviates from the concepts document provided with the sample space program, or from CMS Conditions of Participation, Joint. Commission or AIA Guidelines for the Design and Construction of Healthcare Facilities adopted by the State of Vermont.

D: Define the assumptions and methodology used in developing cost estimates for construction and debt service.

E: Provide a spread-sheet that includes (a) a break-out of construction cost by square foot and per bed, (b) total construction cost and (c) annual and total cost of debt service.

Responsive bids / proposals will reflect these space requirements and renovation and/or construction costs will be based on these attributes.

If the bid or proposal is based on a higher or lower standard, please note the specific divergence and rationale.

3. Program Description and Staffing Plan

The VSH staffing pattern is somewhat unique in that it employs a mix of nursing and psychiatric technicians who provide direct care to patients and are supervised by nurses. The minimum staffing pattern for nursing and psychiatric technicians (PT) that VSH currently employs for the two admission units is the following. This does not include one-to-one staff.

	Day	Evening	Night
Brooks I (19 beds)	2 RN; 1 LPN; 8 PT	2 RN; 1 LPN; 8PT	2 RN; 8 PT
Brooks II (21 beds)	2 RN; 1 LPN; 8 PT	2 RN; 1 LPN; 8PT	2 RN; 8 PT

In addition, VSH currently averages eleven patients per day requiring one-to-one staffing.

Programs providing VSH replacement-level services will need to provide the following capacities, all of which drive a staffing pattern. Any program providing VSH replacement services must be able to serve the most acute admissions and provide back up to the general designated hospital psychiatric programs.

Bids or proposals should address how these requirements will be met with a proposed staffing pattern.

A. Capacity to admit 24-7 and 365 days/year. All admissions require an initial examination by a psychiatrist to assess the patient's medical and psychiatric needs on

arrival and to develop initial physician orders. In addition, VSH requires the initial assessment and treatment plan to be completed by a psychiatrist within eight hours of admission.

B. Provision of emergency involuntary procedures 24-7 and 365 days/year with psychiatrist on-site within one hour to assess the patient. Although CMS standards allow more time before physician review, the Department of Justice requires that VSH meet a one hour standard. In addition, the provision of emergency involuntary procedures such as restraint and seclusion require frequent checks by a Registered Nurse and constant observation by a staff person.

C. Capability to staff patients one-to-one or two-to-one to safely manage acuity and unit milieu.

D. Nursing and staff ratios consistent with the provision of the most acute psychiatric care. In addition, staff are required to transport patients to court hearings and for visits to discharge placements and intake appointments.

E. Medical evaluation and treatment services. Three levels of medical services are required: emergency, urgent, and the capacity to evaluate and treat co-existing medical conditions that so not pose an immediate risk. An example of emergency medical services is "code" response to cardio-pulmonary arrest. Urgent medical care is for conditions that require stabilization within the first hours of an admission such as unstable diabetes (very elevated glucose) and respiratory disease such as COPD and asthma. VSH patients currently present with a wide range of medical conditions requiring evaluation and treatment throughout the course of their admissions.

F. Recovery and psycho-social programming designed to treat patients with treatment refractory mental illness, patients with a slow response to medical and psychosocial interventions, patients who are involuntary and who may be extremely reluctant to engage in recovery, and patients with complex co-occurring conditions (for instance developmental delay, head injury, dementia, and substance use).

G. Capacity to develop complex discharge plans requiring extensive knowledge of the community mental health system and long term care system.

H. Capacity to interface with the ongoing system of care to insure bed availability for the next most acute admission.

I. Capacity to interface regularly with the DMH legal unit and the Mental Health Law Project. Lead the clinical preparation for legal procedures (hospitalization / commitment hearings, applications for involuntary treatment, applications for nonemergency involuntary medication, development of orders of non-hospitalization). Provide psychiatrist testimony at hearings.

Please provide a description of the clinical, medical, and psycho-social programming that is being proposed. Specifically address how this differs from current psychiatric inpatient programs offered by your organization (if relevant).

Please provide a proposed staffing roster by discipline, role, and shift expressed in "Full Time Equivalent" (FTEs).

Describe your organization's ability to recruit and staff this type of specialty programming and any proposed strategies to assure successful recruitment and retention.

4. Licensure and Governance

Please describe what organization will hold the license to operate the program. If this is different from the organization making this proposal please describe how such an organization will be identified (or created) and provide a description of the licensee's relationship to your organization. Identify the board of directors or governing body for the proposed program.

5. Program Costs

Please detail the estimated construction / renovation costs and how these relate to the program of space in number two above.

Please provide a line item budget showing proposed staffing and operations costs. Show annual estimated bed costs and bed day costs.

6. Program Revenues

Please describe the anticipated payer mix and revenues for the proposed program from private insurance, Medicare and Medicaid. Fully describe the assumptions behind the revenue projections provided. Provide your analysis of any barriers to realizing revenues from the payers identified (such as the IMD exclusion, program size limits due to Medicare Critical Access Hospital Designation). Describe your assessment of the likelihood to overcome any identified barriers including and documentation or communication from the Centers for Medicare and Medicaid Services or other relevant certifying and licensing organizations.

7. Impact on the Host Organization or Program and System of Care

Please describe the expected impact of the proposed program on your organization. If, for instance, the bid or conceptual proposal reduces the currently available psychiatric beds, describe the analysis undertaken to determine that the proposal would not undermine the existing system of care.

8. Financial Statements

Please provide the audited year end financial statements for your organization for the past five years.

9. Collaboration Principles between the State of Vermont and a General Hospital

The following outlines the framework by which an inpatient partner and the state will collaborate to develop successor acute psychiatric inpatient programs to replace Vermont State Hospital. This framework would be the basis for any operations agreement and as such any bid or proposal must adhere to these mutual expectations. Please respond fully to the requirements in this framework and indicate which of the approaches to capitalizing new construction or renovation in section 4 the bid or proposal concept would employ.

Guiding Principles

1) Definitions.
In addition to words and terms defined elsewhere herein, the following terms as used herein shall have the following meaning:

a) Program**.** The psychiatric inpatient program operated by the Partner including the Partner's Current Capacity and the proposed New Capacity.
   i) Current Capacity – Partner's existing psychiatric inpatient service at current average daily census, serving voluntary, involuntary and forensic evaluation patients.
   ii) New Capacity – Proposed additional capacity with a care environment, clinical capabilities and support services necessary to serve a higher acuity patient, i.e. patients currently served by Vermont State Hospital.

b) Project**.** The proposed new facility or renovated facility designed and constructed to house the Program.

c) State**.** The State of Vermont acting by and through its Agency of Human Services and Department of Buildings and General Services.

d) Partner**.** The general hospital partner.

e) Designated Agencies. An agency designated by the Commissioner of Mental Health pursuant to 18 V.S.A §8907.

f) DMH. Department of Mental Health of the Agency of Human Services of the State of Vermont.

2) Program Principles.

a) The Program will be an integrated part of the state wide system of care.
   i) The Program will coordinate with ongoing care system via discharge planning and system development.
   ii) The Program will participate in the state-wide care management system to assure that Vermonters have access to the clinically appropriate level of care they require.
   iii) The Program will work with the State and Designated Agencies to assure the continued success and improvement of the mental health outpatient, residential, and emergency continuum of care.
   iv) The State will allocate resources to assure a balanced system of care.

b) The Program will provide high quality, clinically appropriate care for patients who meet inpatient admission criteria.
   i) The Program will serve all patients who meet admission criteria regardless of severity of illness, ability to pay, or legal status.
   ii) The Program will operate as a single inpatient psychiatric program (with different levels of care or treatment milieus) under the license of the general hospital.
   iii) The State and the Partner will work to provide care in the most clinically appropriate setting and use inpatient programs only for those patients who require inpatient level care.
   iv) Psychiatric inpatients will have full access to comprehensive medical center services. Medical, mental health, and substance abuse treatment and care will be fully integrated and coordinated.
   v) The Program will provide active treatment for involuntary patients who meet medical necessity criteria for hospitalization throughout their length of stay.
   vi) The Program will provide non-emergency involuntary medication consistent with Vermont Statute and regulations.
   vii) The Program will meet all relevant standards for hospital licensure, certification by the centers for Medicare and Medicaid Services, hospital accreditation by the Joint Commission and all standards for Commissioner Designation for Involuntary Psychiatric Inpatient Treatment and Forensic Evaluation Admissions.
   viii) Preference for employment in the Program shall be given to the qualified members of the Vermont State Hospital work force.

3) Governance Principles.

a) The Program shall be governed by the Partner's board of directors, management team and medical leadership.

b) A stakeholder advisory panel (consumers, family, and community members) shall be created to advise Partner and Program management on the creation, implementation and performance of the Program.

4) Fiscal Principles.

a) Capital Financing. Fiscal responsibility for capital costs will be allocated between the State and the Partner on a fair and reasonable basis. The State and the Partner will agree on proportionality of investment and relative terms of the final disposition of ownership of the facilities. Capital financing for the Project could come from a variety of sources including: hospital capital investment, State of Vermont capital investment, revenue anticipation bonds, federal grants, private grants, and developer tax exempt financing.

The State identifies the following options for capitalization and disposition of ownership for the Project:

i) Option 1 – The Partner and the State will jointly develop the Project that would eventually be subdivided through a condominium arrangement. Development costs and construction costs would be prorated based on the proportional space allocation of the respective condominiums. Each organization would ensure the availability of capital funds for their respective shares.
ii) Option 2 – The Partner would lead the development of the Project and the State would contractually pledge (debt financing) a proportional share of the funds. The Partner would be the sole provider of development and construction funding as the eventual owner of the entire facility. The State's investment would be protected through contractual operating agreements.
iii) Option 3 - The Partner and the State would jointly identify a private developer to undertake the financing, development, and construction responsibilities. All of the aforementioned sources of funds could be utilized. Final disposition of the Project would be based on the proportionality of investments and operating agreements. Either a condominium arrangement or sole ownership by the Partner would be negotiated.

b) Operations Financing–Fiscal responsibility for operation costs will be allocated between the State and the Partner on a fair and reasonable basis.

i) Program Budget. The State and the Partner will establish an annual line item budget for the Program based on the following:
(1) The State and Partner will commit to an approach of mutuality to determine the allowable costs attributable to the Program budget.
(2) The Program budget will be the basis for the rate structure.
(3) The Program shall be designed to maintain an occupancy rate of (at least) 90% or greater. The overall Program budget will be based on 100% of the costs at this occupancy rate.

(4) Overhead costs allocated to the Program will be mutually agreed upon.
(5) Capitalization costs/ debt service (if any) allocated to the Program will be mutually agreed upon.
(6) The Program line item expenses will be tracked in a separate cost center from that of the Partner. Monthly reports of the revenues and expenses shall be submitted to the DMH business office.

ii) Cost Sharing.
(1) The Partner will pursue all reimbursable costs for all patients through private pay Medicare, Medicaid, and other insurers.
(2) The costs associated with the New Capacity are assumed to be greater than the costs associated with the Current Capacity and any cost sharing arrangement should reflect these two levels of cost/care.
(3) The State will guarantee 100% of the agreed upon expenses for the New Capacity provided the 90% occupancy target is met with patients who would otherwise have been served at VSH.

5) Collaboration Principles Throughout Project Phases

a) Project Phases. The phases of the Project shall be as defined as follows:

i) Planning. The Planning Phase of the Project is the period following the date of an agreement in principle between the State and the Partner and until the filing of the CON application. During the Planning Phase, the parties shall work collaboratively to develop and approve the following definitive materials and documents for the Project, which shall be acceptable to both parties (the "Project Planning Documents"):
(1) A site location and site plan for the Project, including adequate parking;
(2) A Project design with design and development plans and specification in sufficient detail to proceed with the Permitting Phase;
(3) A capital budget for the Project;
(4) A timeline for the Project Phases;
(5) A completed CON application and any other planning documents / elements necessary for a CON application; and
(6) A signed agreement (s) between the State and the Partner that:
(a) describes the clinical program elements for patients admitted to the Program;
(b) defines the terms of ownership, operation, management and financing of the Project and the Program;
(c) binds the parties for as long as the Program is operated by Partner and the Project is used by the Partner for the agreed upon purposes;
(d) includes standard State contract provisions.
(7) The parties shall not proceed to the Permitting Phase unless all of the Project Planning Documents have been approved in writing by both parties.

ii) Permitting. The Permitting Phase of the Project is the period after the Planning Phase has been substantially completed and applications are submitted for the following permits in the following order:
(1) CON,
(2) Once the CON has been approved, local and state zoning and land use permits, all other applicable governmental licenses and permits for the Project.
(3) Final construction documents will be completed.

iii) Construction. The Construction Phase of the Project is the period which follows after all necessary permits have been obtained and final construction documents have been developed, through substantial completion of the construction of the Project.

iv) Operation. The Operation Phase of the Project is the period after (or in the case of preparatory planning, concurrent with) the construction of the Project has been substantially completed and all necessary occupancy permits have been received, including activities related to the preparation for opening the Project and the actual management and operation of the Project for its intended use.

b) A joint project team composed of representatives of the State and the Partner will be established. This team will meet regularly until the Project is completed in order to make joint decisions and to share information concerning implementation of this Agreement and the development of the Project and implementation of the Program.

c) Leadership and respective obligations of the parties during the Project Phases will be assigned by agreement of the parties. Partner, as licensed hospital, will lead the development of the CON application and CON approval process.

d) Stakeholder participation. During the Project Phases and prior to opening of the Program, the Partner shall convene regular meetings of a stakeholder advisory panel (as discussed in Section 3(b) above) to provide feedback on specific, emerging Program and Project characteristics, including:
i) Program design
ii) Development of estimated operating costs
iii) Identification of appropriate facility characteristics and site
iv) Development of estimated construction / renovation costs
v) Development of CON application
vi) Community outreach and engagement

e) Communications. The State recognizes the importance of effective communication, consistent with these Collaboration Principles. The State and the Partner will:

i) Not make any public statements concerning the position of commitments of the other party with respect to the Project (confidential and proprietary

information) without the consent of the other party, except as may be required by applicable State law.

ii) Coordinate all public statements and presentations concerning the Project and the Program by sharing such communications with each other and seeking input before the communication is made.

iii) Be inclusive and transparent in appropriately communicating non-confidential information concerning the Project with the public and other interested parties as such information is developed.

iv) Appropriately solicit and consider input from each other and from interested parties concerning the Project as it is being planned and developed.

PROPOSAL/BID REVIEW

Review Process

Staff from DMH will review proposals/bids for compliance with RFP procedural requirements. If the procedural instructions are not followed, the proposal shall be considered non-responsive. Non-responsive proposals will be eliminated from further evaluation or returned to the bidding agency to address minor irregularities.

In addition to the review done by DMH staff, a review panel composed of stakeholders will be convened to review proposals, rate their merits and submit this information to the Commissioner of Mental Health for development of a draft Master Plan. Proposals judged to have the best overall merits will be included in the draft Master Plan.

The draft Plan will be provided to the Joint Fiscal and the Mental Health Oversight Committees for their review and consideration. Additional planning, CON preparation, and appropriation requests will follow based on the Master Plan in concurrence with the legislative oversight committees.

Scoring

Proposals will be scored by individual Review Panel members. The proposal's preliminary score will be the sum of the scores from individual review team members. Review panel member recommendations and comments will also be forwarded to the Commissioner for consideration.

The following weight is assigned to each component of the RFP:

	Weight	Maximum Points	Weighted Total
(1) Required Program Elements	**2**	**25**	**50**
(2) Facility	**1**	**25**	**25**
(3) Program Cost & Revenues	**1**	**25**	**25**

Total Maximum Individual Scores 100

Appendices

Request for Proposals or Bids

By the Agency of Human Services
For
Psychiatric Acute Care Services
To Replace Vermont State Hospital

Concepts underlying the program of space

The program of space should be built around the ideas of client-directed, trauma informed care and based on treatment programming needs of the VSH patient population groups. It should compare favorably with national norms, guidelines and architectural standards adopted by state-of-the-art providers. Design assumptions should include but not be limited to the following propositions:

- There should be all-private bedroom environment with en-suite patient bathrooms.
- There should be multiple autonomous residential sub-units of eight to ten beds each located within each single administrative nursing unit.
- The space program should reflect the full range of clinical, administrative, operational and adjunctive therapies support available at a typical modern free-standing state hospital.
- The facility must meet CMS Conditions of Participation, Joint Commission standards and AIA Guidelines for the Design and Construction of Healthcare Facilities that have been adopted by the State of Vermont.
- An attempt should also be made to incorporate the latest trends and innovations in patient centered spatial designs that have emerged across the country.
- The environmental design should promote autonomy, foster resident engagement in recovery and support clinical programming in which reliance on coercion and the use of involuntary medication will be avoided.
- The safety and security of patients and staff are paramount concerns.
- The facility should have a non-institutional design.
- It should seem open and inviting with much natural light.
- The design should maximize the safe and secure movement of patients in an unrestricted manner.
- Direct, discrete and secure access to the service on admissions is required.
- There should be a separate admissions area with facilities for short-duration triage and assessment.
- Space to use as a court room is needed on-site.
- There should be easy access to the outdoors for all patients.
- Ensuring patient privacy and the confidentiality of patient information is a high priority. In this regard, some visitors' rooms should be located off the residential portion of the patient unit in a more "neighborhood-like" area.
- Where possible, conference rooms, meeting rooms, copy and file rooms, staff lounges, locker rooms and toilets will be shared among departments.
- Smoking anywhere in the building will be prohibited
- It is assumed that current average length of stay is variable, ranging from nine (9) days to over thirty (30) days

Sample Program of Space 16-20 Bed Inpatient Unit

SAMPLE PROGRAM
OF SPACE 16-20 ...